

**FORM A: FACE PAGE**

This form requests basic information about the Applicant and project, including the signature of the authorized representative.  
The face page must be completed in its entirety.

**APPLICANT INFORMATION**

1) LEGAL BUSINESS NAME: WOMEN'S HEALTH CARE CENTER, INC.

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):  
2914 S BUCKNER STE B DALLAS TEXAS 75227

3) PAYEE Name and Mailing Address (if different from above):

4) DUNS Number (9-digit): 829195259

5) Health and Human Service Region:  
2

6) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or Social Security Number (9 digit): 943432832

\*The Applicant acknowledges, understands and agrees that the Applicant's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

7) TYPE OF ENTITY (check all that apply):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> City                        | <input checked="" type="checkbox"/> Nonprofit Organization* | <input type="checkbox"/> Individual                                      |
| <input type="checkbox"/> County                      | <input type="checkbox"/> For Profit Organization*           | <input type="checkbox"/> Federally Qualified Health Centers              |
| <input type="checkbox"/> Other Political Subdivision | <input type="checkbox"/> HUB Certified                      | <input type="checkbox"/> State Controlled Institution of Higher Learning |
| <input type="checkbox"/> State Agency                | <input type="checkbox"/> Community-Based Organization       | <input type="checkbox"/> Hospital  |
| <input type="checkbox"/> Indian Tribe                | <input type="checkbox"/> Minority Organization              | <input type="checkbox"/> Private   |
|  | <input type="checkbox"/> Faith Based (Nonprofit Org)        | <input type="checkbox"/> Other (specify): _____                          |

\*If incorporated, provide 10-digit charter number assigned by Secretary of State: 0800987809

8) BUDGET PERIOD: Start Date: July 1, 2016 End Date: August 31, 2017

9) COUNTIES SERVED BY FAMILY PLANNING PROJECT: (complete Form C: Texas Counties and Regions) DALLAS

10) PRIMARY PLACE OF SERVICES PROVIDED 2914 S BUCKNER STE B DALLAS TEXAS 75227

11) TOTAL FUNDING REQUESTED: 300,000

Fee for Service: \$300,000

Categorical: 0

12) PROJECTED EXPENDITURES

Does Applicant's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for Applicant's current fiscal year (excluding amount requested in line 9 above)? \*\*

Yes No X

\*\*Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.

13) FAMILY PLANNING (FP) PRIMARY CONTACT PERSON

Name: SHERRY TENISON RN, EXECUTIVE DIRECTOR

Phone: 214-275-5256

Fax: 214-275-5284

Email: SHERRY.TENISON@YAHOO.COM

14) FINANCIAL OFFICER

Name:

Donnie

Graham

Phone 214

Fax: 214

275-

5284

Email: Do

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Graham

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The facts affirmed by me in this proposal are truthful and I warrant the Applicant is in compliance with the assurances and certifications contained in APPENDIX I: HHSC Assurances and Certifications. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the Applicant and I (the person signing below) am authorized to represent the Applicant.

15) AUTHORIZED REPRESENTATIVE

Name: Sherry Tenison RN Executive Director  
Title: Executive Director

16) SIGNATURE OF AUTHORIZED REPRESENTATIVE

17) DATE

8/1/2016

Revised

Phone: 214-275-5256  
Fax: 214-275-5284  
Email: [sherryt@sonnet.com](mailto:sherryt@sonnet.com)

8-1-2016

Revised

